PATIENT REGISTRATION FORM

(Please print clearly)

Email Address: _____ SS#_____

Preferred Contact Number? _____ May we leave a message? Yes___ No___

Marital Status: _____ Preferred Language: _____

Race:
- ☐ White
- ☐ Black/ African American
- ☐ Asian
- ☐ American Indian/ Alaskan Native
- ☐ Native Hawaiian/ Pacific Islander
- ☐ Other

Are You:
- ☐ Hispanic/ Latino
- ☐ Non Hispanic/ Latino

Responsible Party (if different from patient) **Must be completed if the patient is a minor.

First Name: _____ MI: _____ Last: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Relationship to Patient: _____

With whom may we contact in case of an emergency or leave medical information with? Indicate whether or not we may discuss medical information pertinent to your treatment with this person.

Name: _____ Relation: _____ Phone #: _____ Yes/No

Name: _____ Relation: _____ Phone #: _____ Yes/No

***** By signing on the next page, you certify the information above is correct and agree to the terms of the Financial Responsibility and Release Form.**

Blue Water Surgery Center **6830 S US Highway 1 Port St. Lucie, FL 34952** **Phone: 772-873-6700 / Fax: 772-465-5499**	**Patient Label Here** **Revised: 10/14/2020**

AMBULATORY SURGERY CENTER
PATIENT CONSENT TO RESUSCITATIVE MEASURES

NOT A REVOCATION OF ADVANCE DIRECTIVES OR
MEDICAL POWERS OF ATTORNEY

All Patients have the right to participate in their own health care decisions and to make advance directives or to execute powers of attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. This surgery center respects and upholds those rights.

However, unlike in an acute hospital setting, the surgery center does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no surgery is without risk. You will discuss the specific of your procedure with your physician who can answer your questions as to its risks, your expected recovery and care after your surgery.

Therefore, it is our policy, regardless of the contents of any advanced directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive or health care power of attorney. If you do not agree to this policy, we are pleased to assist you to reschedule the procedure.

Please check the appropriate box in answer to these questions. Have you executed an advanced health care directive, a living will, a power of attorney that authorizes someone to make health care decisions for you?

☐ YES, I have an advance directive, living will, or health care power of attorney.
☐ **COPY OF DOCUMENT IN CHART**

☐ No, I do not have an advance directive, living will, or health care power of attorney
☐ I would like information on Advance Directives.

If you checked the first box "YES" to the question above, please provide us a copy of that document so that it may be a part of your medical record.

By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.

By: _____
(Patient's Signature)

If consent to the procedure is provided by anyone other than the patient, this form must be signed by the person providing the consent or authorization.
I acknowledge that I have read and understand its contents and agree to the policy as described.

By:_____ Relationship: _____

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FINANCIAL RESPONSIBILITY AND RELEASE FORM

FINANCIAL RESPONSIBILITY

Charges for services provided by the Blue Water Surgery Center ("the Center") cover the following components: use of the procedure room, equipment and recovery room; all supplies and medications used during your stay; and any lab test performed at the Center. We require payment of your copay or deductible amount, if applicable, on the date of your procedure. If you are unable to pay this amount in full on the day of procedure, you will be asked to sign a promissory note detailing the payment amount and due date of the remaining balance.

Fees for physician services, procedural assistants, Anesthesiologist/Anesthetists, pathologists, laboratory work performed outside the Center and implants are separate from the Center's fee and your responsibility for payment for these fees is between you and the provider of the services.

We will submit a claim to your insurance carrier within 48 hours of receiving complete billing information. You will be notified when final action (payment, denial, etc.) by your insurance carrier has been received. If any additional funds are owed, payment will be expected within 10 days of receipt of that notice. In the event that any such amount is placed with our collection agency, you will be responsible for the collection fees, reasonable attorneys' fees and court costs. A $25.00 services charge will be added to your account for checks returned due to insufficient funds.

We file your insurance claim for you as a courtesy to you; however, our relationship is with you, not your insurance company. It is your responsibility to be knowledgeable regarding your insurance coverage and benefits. We will expect your assistance in obtaining payment from your insurance company if difficulties arise. After 90 days, with certain exceptions, the balance will become payable in full by you. In the event that any such amount is placed with our collection agency, you will be responsible for the collection fees, attorney's fees and court costs.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to the Blue Water Surgery Center of any medical and/or procedural insurance benefits otherwise payable to me or on my behalf for the procedure(s) performed at the Center, at a rate not exceed the Center's regular charges. This assignment of benefits is valid for all insurance companies and programs including Medicare, private and group insurance, workers' compensation or other health plan payments.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize that Center to release medical information concerning the procedure(s) performed at the Center to the extent necessary to determine liability for payment and to obtain reimbursement. The Center may disclose portions to the medical record to any person, corporation or other entity who or which is or may be liable for any of the Center's chargers. This includes, but is not limited to, insurance companies, health care service plans, and worker's compensation carriers. I authorize the Center to obtain medical information, from my physician(s), to the extent necessary to determine liability for payment or continuation of care.

CONSENT FOR OBSERVERS

I consent to the admittance of observers to the procedure room during my procedure for the purpose of advancing medical education.

CONSENT TO PHOTOGRAPH

I consent to the photographing or videotaping of my procedure as deemed necessary by my physician, for scientific to education purposes provide my identity is not revealed by the images or descriptive text accompanying them. I understand that these photographs and/or videotapes are the exclusive property of my physician. **I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS EXCEPT AS CROSSED OFF AND INITIALED.** A photocopy of this authorization shall be considered as valid as the original.

ACKNOWLEDGEMENT

I received the Privacy Notice and the Patient Rights and Responsibilities notice.

_____ _____

Patient's or Guardian's Signature **Date**

_____ _____

Witness **Date**

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